STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

July 5, 2017

Mr. Kurt Barwis, President & CEO
Bristol Hospital
Brewster Rd
Bristol, CT 06010

Dear Mr. Barwis:

Unannounced visits were made to Bristol Hospital on June 15 and 16, 2017 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation.

Attached is the violation of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which was noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by July 19, 2017 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.);
2. Date corrective measure will be effected;
3. The institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and
4. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Cheryl A. Davis, R.N., B.S.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CAD/PB:jf

Complaint #21792

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b)

DATES OF VISIT: June 15 and 16, 2017

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Administration (2) and/or (d) Medical records (3) and/or (e) Nursing service (1).

1. Based on a review of clinical records and interviews, for one of twenty records reviewed for emergency services, (Patient #1), the hospital failed to ensure the record was accurate in that the RN documented a nursing assessment although she did not assess the patient. The finding include the following:

   Patient #1 presented to the Emergency Department (ED) on 6/5/17 at 10:15 AM, with complaints of right scrotal pain for the past three days. Review of the triage record completed by RN #1 identified that she evaluated the patient at 10:16 AM, documented the patient's mode of transport, code status, complaint history, Glasgow coma scale (GCS), pain score, vital signs, sepsis screening, height, weight, immunization status, social history, hearing impairment, suicide risk screening, past medical history, fall risk assessment, and triage priority.

   Record review and interview with RN #1 on 6/15/17 at 10:05 AM stated she triaged the patient on 6/5/17 at 10:16 AM, identified that the ED was very busy that day and since fast track was opening at 11:00 AM she slotted Patient #1 into room #24. RN #1 further stated that she asked the Nurse Aide (NA) to bring the patient back to the room, however, the patient was unable to be located. RN #1 requested that the NA check the bathrooms and call for the patient a second time and when there was no response, she notified the Physician Assistant (PA) that the patient left without being seen and entered this information into the patient's record.

   Review of the clinical record dated 6/5/17 at 10:16 AM identified that RN #2 documented the following assessments: pain, neurological, cardiovascular, respiratory, ears, eyes, nose, throat, gastrointestinal, urological, musculoskeletal, ambulation, (2 person assist), integumentary, psychiatric, and fall risk with safety interventions noted. Interview with RN #2 on 6/15/17 at 11:10 AM stated she did not assess the patient however, entered assessments based on the triage assessment with the assumption that she would edit the information once she received the patient in fast track. RN #2 further stated she failed to delete this information once it was determined that the patient had left without being seen.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical staff (4)(A) and/or (d) Medical records (3) and/or (e) Nursing service (1).

2. Based on a review of clinical records, staff interviews, and ED Nursing guidelines, for one of three patients who presented with a cardiac complaint (Patient #19), the hospital failed to ensure that an EKG was completed in a timely manner. The finding includes the following:

   a. Patient #19 presented to the ED on 6/5/17 at 12:04 PM after being sent in by a walk in clinic for question of an abnormal EKG, chest pain and dizziness for two days. Review of the record with the ED Clinical Coordinator on 6/16/17 at 12:15 PM indicated that

THE FOLLOWING VIOLATIONS OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the patient was triaged at 12:26 PM. The record failed to reflect that an EKG was done when the patient initially presented to the ED. Interview with the ED Clinical Coordinator on 6/16/17 at 12:15 PM stated he was not sure why an EKG was not completed and based on the presentation there should have been an EKG obtained.

Review of the Emergency Department Nursing guidelines for patients presenting with chest pain and/or shortness of breath identified a standing order to obtain an EKG within 10 minutes of arrival.